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ABSTRACT

Developed by a regional health consortium, this plan defines the purpose of planning for consumer health education; explores the implications of recent legislation and historical precedents on consumer health education and consumer participation in the health planning process; documents current activities; develops priorities for future efforts; discusses current problems in the system; and recommends actions necessary to insure adequacy and quality in consumer health education. The plan also includes an analysis of inventories of current or potential activities or providers of consumer health; mortality and morbidity data for the Orange County planning region; documentation of existing planning and coordination efforts; discussion of coordinated activities promoting innovation and creative approaches, barriers to current health care and health education utilization, and the need for a comprehensive consumer health education dissemination system. The need and possible methods to insure participation from consumers who represent consumer/community-based interests are also addressed. It is recommended that a single agency be designated to plan, coordinate, and implement a comprehensive consumer health education system with appropriate level of funding to discharge responsibilities.
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Chairman, Board of Directors 1975-76

Calvin Davenport, Ph.D.
Chairman, Board of Directors 1974-75

Shirley A. Komoto
Program Coordinator

Margaret Jean Orchard
Executive Director

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ORANGE COUNTY - LONG BEACH HEALTH CONSORTIUM, INC.
2021 Business Center Drive, Suite 204
Irvine, California 92715
(714) 833-2073

2 714 832 1841

CE 012105

ORANGE COUNTY - LONG BEACH HEALTH CONSORTIUM, INC.

CONSUMER HEALTH EDUCATION PLAN

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ABSTRACT

The Consumer Health Education Plan is one of three plans developed by the Orange County - Long Beach Health Consortium in 1975-76. Other plans are the Health Manpower Information Plan and the Continuing Education Plan. The Consumer Health Education Plan addresses consumer health education planning in Orange County, California as per contract number ROP 75G-715-0-H151 by California Regional Medical Program.

The Plan defines the purpose of planning for consumer health education; explores the implications of recent legislation and historical precedents on consumer health education (CHE) and consumer participation in the health planning process; documents current activities; develops priorities for future efforts; discusses current problems in the system; and recommends actions necessary to insure adequacy and quality in consumer health education for consumers in this geographic area.

The analysis includes: inventories of current or potential activities or providers of consumer health education, including voluntary and public health agencies, health care providers, educational institutions and schools, and professional health manpower associations; mortality and morbidity data for the Orange County planning region; documentation of existing planning and coordination efforts; discussion of coordinated activities promoting innovation and creative approaches; barriers to current health care and health education utilization; and the need for a comprehensive consumer health education dissemination system. Also addressed is the need and possible methods to insure participation from consumers who truly represent consumer/community-based interests.

The Consortium recommends that a single local agency be designated to plan, coordinate, and implement a comprehensive consumer health education system with appropriate level of funding to discharge responsibilities. It is further recommended that the Orange County - Long Beach Health Consortium be designated the health manpower - Consumer Health Education planning body for this planning region.

The Plan is one of nine being completed in the California Network of Health Sciences/Manpower Education Consortia in 1976 and will prove useful to health planning groups, community groups, schools, health providers, and consumer health advocates. This plan has been designed to comply with the Consortium activities transitional to the establishment of the Health Systems Agency (PL 93-641) and will provide the HSA with information on the status of Continuing Education in the region.

The Orange County - Long Beach Health Consortium, Inc. is a non-profit corporation which has been established in 1974 with the goal of providing articulation and linkages between educational institutions and health care providers and to stimulate consumer health education within Consortium boundaries. The Consortium area includes all of Orange County and the cities of Long Beach, Lakewood, Norwalk, Hawaiian Gardens, Signal Hill, Artesia, Cerritos, Avalon, and Bellflower in Los Angeles County. These jurisdictions comprise a total land area of approximately 1,000 square miles with an approximate population of 2.5 million people.

The Orange County - Long Beach Health Consortium is one of a Statewide Network of 16 Health Sciences Educational Activities (HSEA's). The Consortium is currently funded through a grant from California Regional Medical Program.

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ORANGE COUNTY - LONG BEACH HEALTH CONSORTIUM, INC.

CONSUMER HEALTH EDUCATION PLAN - 1976

INTRODUCTION

The Consumer Health Education Plan is one of three plans developed by the Orange County - Long Beach Health Consortium in 1975-76. Other plans are the Health Manpower Information Plan and the Continuing Education Plan.

The Consumer Health Education Plan addresses consumer health education planning in Orange County, California (Health Services Area #13 - OC/LB Planning Region A) (Appendix F) as per contract number ROP 75G-715-O-H151 by California Regional Medical Program (1975-76).

This Plan documents what is being done in consumer health education; identifies what needs to be done; develops priorities for future efforts; and recommends actions necessary to insure adequacy and quality in consumer health education in this geographic area.

Definitions

"Consumer health education" has been broadly defined as any education about health for the general public.

In this sense, the term "consumer" refers to any person or group of people using health education materials or participating in a health education activity or program.

Consumer health education incorporates preventive, therapeutic and rehabilitative factors in health and imparts this knowledge to create attitudes and behavior leading to a positive health regimen and the well-being of both mind and body.

This definition is not limited to didactic formal classroom activities, but includes any attempts to disseminate information about health. It also includes all age groups, adults and children.

A consumer health education "provider" is any individual, group, agency, association, or institution which disseminates or presents information about health to the general public. This includes the various types of media, educational institutions, and consumer groups as well as health care providers.

The section of this Plan which addresses consumer participation in health planning and health services delivery will use the definition of "health consumer" as stipulated by PL 93-641, the Health Planning and Resources Development Act of 1974, and clarified in the Federal Register of December 19, 1974.

For members participating in health planning on governing bodies or other committees stipulated in the Health Planning and Resources Development Act of 1974, a "health consumer" designation must be in accordance with the strict guidelines defining health consumer and health provider. (Appendix R).

A "health consumer" is defined as "an individual who receives health services" and who is not a health provider. (Appendix R).

The definition for "health provider" is far more explicit and is included in the Appendix (Appendix R) as clarified in the Federal Register (12/19/74) and included in the County of Orange Health Systems Agency Designation Application, 1976.

In brief, a health provider is any direct or indirect health care provider including spouses and immediate family. This includes any person or persons deriving more than one-tenth of their gross annual income from health-related interests.

Purpose

This Plan will review and describe what is known about the present conditions in consumer health education. The Plan will address the needs of the general public for access to available health resources and knowledge; methods to involve the consumer in a health education program imparting knowledge, attitudes and behaviors which will result in a proper health regimen, including preventive health measures; and methods to encourage consumer participation in the health planning process.

This Plan will include information on local consumer health education resources and activities to be used by other consumer health education, health, and human services providers. It will summarize local known consumer health education activities to date in this area.

This analysis will also examine the significance and role of consumer participation in the health planning process. Recommendations will be made addressing the process of involving the consumer in the system and in his own health care.

Variables affecting or affected by the current system will be considered as issues are identified and recommendations for improving the system are proposed.

This plan is one of nine Consumer Health Education Plans being completed in the California Network of Health Sciences/Manpower Education Consortia in 1976. The Plan will prove useful to health planning groups, community groups, schools, health providers, and consumer advocates in health.

The Plan has been designed to comply with the Consortium activities transitional to the establishment of the Health Systems Agency (HSA) and will provide the HSA with information on the status of consumer health education in the region.

Rationale

In America, education has been the traditional tool for imparting knowledge and modifying behavior. Advancement of knowledge, alone, makes it necessary to re-educate the consumer. Many health goals are unattainable without certain learned behavior even though there are positive behavioral patterns which are unconsciously acquired. There are educational or teaching-learning components in all health-related activities. An individual must learn to brush his teeth for dental health, or learn that smoking and illegal drugs can be hazardous to his health. The consumer must learn that a good health regimen and close adherence to well-proven medical treatment may increase his life expectancy, and the potential quality of that life.

Access to the information on pre-natal care or a well-balanced diet is only one step in the process. The consumer must also learn to integrate the information into his living style, developing behavior and attitudes which take advantage of the knowledge.

Individual goals of immediate gratification tend to interfere with the development of a healthy life style. The cessation of pain is often the signal for individuals to resume habits which are unhealthy. There must be a change in behavior indicating the individual has assimilated the information and incorporated it into his lifestyle.

Consumer health education is the tool to impart knowledge and modify behavior. It is not only to the advantage of the individual consumer, but also impacts the health care delivery system. Armed with the proper knowledge, the consumer may make proper use of existing health care resources and preventive health care measures which will result in a cost savings to the consumer and to the system.

Each of these, alone, is reason enough for coordination and greater articulation of consumer health education activities. Combined, these factors and others call for careful planning to insure the most efficient use of available resources and the effective delivery of programs to provide a climate for the development of proper health attitudes and behaviors.

Consumer Health Education: A Brief Background

Consumer health education has historically been recognized as an influencing factor in health care behavior and problems.

In the summary of positions and recommendations of the National Commission on Community Health Services, (1966), health education is addressed as a fundamental aspect of community health services, basic to every health program. Education for health should stimulate each individual to assume responsibility for maintaining personal health throughout life and to participate in community health activities.

Voluntary consumer participation in health planning and direct services was initially addressed in PL 89-239, establishing Regional Medical programs in 1965. Also included were concerns for implementation, access, and utilization of consumer health education programs.

This was followed by PL 89-749, the Comprehensive Health Planning Act of 1966, more commonly known as the "Partnership for Health Act." Significant because it mandated consumer representation and consumer majority on all comprehensive Health Planning Agency (CHP) Boards at the local levels, implementation of this law initiated a continuing controversy with questions such as: "what is a consumer," "who does he represent," "how does he maintain accountability to his constituency," and "how can he plan without expertise."

The Health Resources Planning and Development Act of 1974, PL 93-641, was an attempt to consolidate all health planning and evaluation activities and responsibilities into one agency. The law also attempts to further insure and clarify the definition and role of the consumer in health planning. The following section discusses consumer health education and consumer participation as included in PL 93-641.

PL 93-641

The National Health Planning and Resources Development Act of 1974, PL 93-641, provides for the creation of Health Systems Agencies (HSA's) at the local, state, and federal levels, which will assume the responsibilities of planning and developing health services for the entire country.

Consumer health education is an integral part of the health care delivery system and, as such, has been recognized in the Act.

Section 1502 designates ten national health priorities. "The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions..." (Section 1502 (5)) was intended to apply to cooperative sharing of resources to prevent unnecessary duplication of services and systems, thus reducing costs of care. The phrase "multi-institutional arrangements" can also be interpreted to include shared consumer health education programs and resources. A cooperative arrangement linking health care institutions with other consumer health education providers would maximize utilization of limited resources and help to locate offerings in geographically removed areas.

The public health departments, hospitals, voluntary health agencies, and individuals and groups of consumers should cooperate to offer health education. This cooperative support service would be effective in reaching a larger base in the community through the involvement of community members. It would also be more effective in reaching those interested in a specific health problem, particularly with agency cooperation and referral of appropriate patients.

These kinds of arrangements to share consumer health education resources as a support service integral to health care delivery can lead to system improvements that streamline existing patient education services resulting in cost reductions.

The phrase "multi-institutional arrangements" may also be interpreted to include shared educational programs for patients, people from the community, and staff, as well as treatment of diseases categorically (e.g. cancer hospital). This section of the law could then be interpreted to mandate cooperative planning, coordination, and delivery of consumer health education services, such as training for patients and families dealing with coronary, renal, and metabolic diseases.

"The promotion of activities for the prevention of disease including studies of nutritional and environmental factors affecting health and the provision of preventive health care services," (Section 1502 (8)) as a national health priority, further addresses the need for consumer health education. This section alludes to the planning, coordination, and delivery of public health education. The concept of preventive health care includes a coordinating and distributing vehicle for the body of knowledge and data collected, and techniques and methods developed for prevention of disease and illness. This section is, furthermore, consistent with the concept of consumer health education and the prevention of disease and illness through an educated public.

Activities complying with this section of PL 93-641 would include studies documenting existing consumer health education providers, programs, and activities. In this regard, the Consumer Health Education Study - 1975 of the Orange County - Long Beach Health Consortium is consistent with the intent of the law. Expansion and update of the Study would increase knowledge to be used for planning and coordination and promote further activities for disease prevention.

"The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services" (Section 1502 (10)) formally recognizes and directly mandates a coordinated consumer health education system.

The planning, coordination, and data collection functions of the Health Systems Agency (Section 1513) have been established for the expressed purposes of improving health, restraining cost increases, preventing unnecessary duplications, and "increasing the accessibility...acceptability, continuity, and quality of the health services provided..." (Section 1513 (a) (2)).

Furthermore, the evaluation and review of health systems agencies by the Secretary of H.E.W. shall be based on determinations to include "the extent to which it may be demonstrated that...the accessibility, acceptability, continuity, and quality of health care...has been improved..." (Section 1535 (c) (7) (B)).

Finally, the performance and functions of each State Agency by the Secretary of H.E.W. shall also include "the extent to which it may be demonstrated that...the accessibility, acceptability, continuity, and quality of health care in the State has been improved..." (Section 1535 (d) (6) (B)).

Increasing accessibility and acceptability of health services, mandated for purposes of review and evaluation, clearly indicates provisions for consumer health education. An informed public, armed with knowledge of health care services and resources, can more easily have access to facilities. Increased knowledge may also reduce the element of apprehension and fear, making services more acceptable to the consumer.

To insure consumer participation and authority in the health planning process, PL 93-641 mandates stronger authority and more control by the HSA over investments of Federal and State health dollars than has ever been given to a local health planning agency. In addition, this law mandates that a majority (51% to 60%) of consumers must be members of the HSA policy board. These consumers must represent the special consumer interests existing in the area.

These special consumer group interests are defined as the social, economic, linguistic, racial, and employment circumstances creating problems for consumers when they require health care.

To insure equal treatment and representation to the various special interest groups in the community (including consumer and provider interests) the HSA may establish Sub-Area Advisory Councils to represent each part of the health service area that has special and unique health planning and resource problems. The special concern may be a geographic section or a group of people with special needs. Consumers who represent a special geographic area or group of people in the Health Service Area would organize sub area advisory councils to represent their interests. Any agency filing an application to be designated an HSA must indicate in the application how equal representation will be guaranteed.

STATEMENT OF THE PROBLEM

An assessment of the consumer health education (CHE) needs must be based upon a combination of factors including: the nature, scope and distribution of existing programs; mortality and morbidity data illustrating health care problems of particular significance in this geographic area; available manpower to provide consumer health education and consumer perceived (felt) needs; utilization of existing consumer education resources.

Education of the patient is essential to the principle of preventive medicine. It relates to the efficient use of the time and talents of the health care workers and thereby to the costs of medical care.

In determining what consumer health education programs are required, documentation of the needs of the population as compared with the capacity of available resources to provide the programs must be accomplished. There is currently no mechanism to accurately measure the CHE needs of local residents. CHE planning is not coordinated either regionally or locally. There are, however, various agencies, groups and institutions that can be integrated into a cooperative system to reduce current fragmentation.

The Orange County - Long Beach Health Consortium is the only organization involved in developing an area-wide plan examining and recommending rational alternatives for the planning, coordination, and delivery of consumer health education activities.

Determination of the consumer health education needs, the assessment of existing resources to adequately fulfill the needs, and promotion of preventive approaches to health care must be accomplished through documentation and subsequent analysis of factors including:

1. Inventory, description, and analysis of local operational and planned consumer health education programs.
2. Accessibility of offerings.
3. Mortality and morbidity data; health profile for region and breakdown by area, ethnicity, sex, age.
4. Consumer input, participation and documentation of consumer "felt" needs.
5. Changing health care delivery patterns impacting consumer health education.

6. Costs of consumer health education, including reimbursement programs, methods of charges, stipends, etc.
7. Existing efforts in coordination, planning, evaluation, and implementation of consumer health education programs.
8. Trends in recommendations and requirements for consumer health education, particularly by government agencies.
9. New legislation addressing CHE.
10. New trends in CHE delivery.

Planning is a continual process which has too often been conducted in a vacuum unaware of the existing body of data and isolated from outside input. To best utilize current resources, efforts must be made to review and include existing consumer health education information (studies, research, resources) in the planning process. This will prevent duplication of efforts and re-generation of already identified data.

Existing materials related to consumer health education have been reviewed by the Consortium. Two major publications documenting CHE activities regionally, produced by the Coordinating Council for Health Science Education, San Diego and Imperial Counties and the San Joaquin Valley Health Consortium have been invaluable resources in the development of this Consortium's Consumer Health Education Study - 1975 and subsequent development of this Consumer Health Education Plan - 1976.

Additional resources included in the Bibliography have been reviewed and appropriate information is included in this Plan.

Continued review of literature addressing consumer health education will insure proper use of documented activities and prevent duplication of efforts. This will also increase the ability of planners and CHE providers to keep abreast of the issues and priorities as defined by other individuals, agencies, and organizations.

Analysis of Consumer Health Education (CHE) Activities and Resources

The identification of consumer health education programs and efforts is prerequisite to documentation and projections of the needs. Annual updating of information is necessary to insure accurate and timely data and in order to project trends and effects of new policy issues.

Resources identified in the consumer health education system must be addressed in an in-depth description and analysis including:

1. Operational and planned programs; their description, objectives, and directions.
2. Affiliations and relationships to other programs and resources.
3. Geographic location and costs.
4. Audience addressed including educational level and primary language spoken.
5. Program outreach.
6. Community participation.
7. Dissemination of program information.
8. Program utilization: real or projected.
9. Academic credits for course.

Consumer health education providers must be identified. This process is made difficult by varying definitions of consumer health education and the proliferation of these activities offered at levels ranging from major medical centers to grass-roots, store-front operations. The Consortium definition of consumer health education is "any education about health directed towards the public (consumer)." The Consortium has begun to develop current information identifying potential CHE providers as the first phase in a comprehensive survey of programs and activities related to health for the consumer.

Inventories of potential providers completed to date are in the following categories: public/governmental; voluntary health agencies; health care providers (acute care and skilled and intermediate care facilities); educational institutions (postsecondary); and professional health manpower organizations.

In addition, the Consortium plans to develop inventories on other categories of CHE providers as they are identified, including:

1. Community groups - includes local single-function or comprehensive programs organized and operated within a specific area or for a specific population such as senior citizens programs, ethnic centers, consumer health groups.
2. Churches - associations and/or councils of churches, regionally organized, local, and church-affiliated groups.
3. Health planning bodies.
4. Expansion of educational institutions and education-related groups to include all educational levels, parent associations, etc.
5. Expansion of the Health Care Providers sector to include out-patient clinics and other providers offering consumer health education.
6. Unions and other employers offering group or health insurance coverage.
7. Patient advocate groups such as "Reach to Recovery," "Osteotomy Club," "Mended Hearts."

Voluntary Health Agencies/Public Governmental Sector:

The Public/Governmental Sector includes city, county, state and federal agencies located within Consortium boundaries involved in CHE.

The Voluntary Health Agencies include major single-function/concern agencies with multiple offices serving specific areas, such as the American Heart Association and the American Cancer Society. (Appendix L).

The public/governmental and voluntary health agencies identified in Orange County, Planning Region A, and greater Long Beach, Planning Region B, have been generated by the Consumer Health Education Committee and Staff of the Consortium. A comprehensive inventory was developed through use of existing resources including: lists, membership rosters, telephone books, library holdings, and published resource books and pamphlets.

Resource holdings developed and published by Community Referral Information Service (CRIS) were used for updating some addresses, phone numbers, and

contact persons. In addition, inventories were made available by the Orange County Health Planning Council (CHP "B") for further documentation of resources in these sectors.

The Consumer Health Education Study - 1975 documents 32 public and voluntary health agencies involved in CHE activities. (Appendix X).

The Study is organized into two chapters: Chapter I, entitled "Consumer Health Education Resources - Topical Listing," and Chapter II - "Alphabetical Listing of Participating Agencies." Chapter I includes the participating agencies by areas of concern, health topics covered, and health-related activities. CHE activities are in alphabetical order. The priority, as stated by the agency, has been added to give a clearer indication of the agency's functions and directions. Chapter II is the information on the participating agency, including: address, hours of operation, affiliations, present and planned activities, staffing, charges and fees, media utilized, holidays observed, and languages in which the CHE materials are available. The two chapter design was developed to enable the reader to refer either to the particular area of concern or the specific agency of interest. A summary of the Study (Appendix T) reviews the survey methodology and the recommendations. An inventory of CHE providers in the voluntary/public sectors has been developed from the survey. (Appendix M).

Health Care Providers:

A partial inventory of this sector has been developed and a sample of activities in an acute care facility is highlighted to exemplify the importance of documenting CHE activities in this area.

The Health Care Providers sector includes acute care facilities, skilled nursing facilities, and clinics which provide patient, family, and/or community health education.

The inventories of Acute Care Facilities and Skilled and Intermediate Care Facilities were generated with the assistance of the Orange County Health Planning Council, and is an update of the list included in the 1975 approved Health Facility Plan for Orange County. The inventories represent data current to November, 1975. There are currently forty acute care facilities (Appendix B) and sixty-three skilled and intermediate care facilities (Appendix H) in Orange County.

Health care providers are offering varying types of consumer education. Acute care facilities, in particular, are discovering the increasing need for patient and family education to assist in the management of an illness.

St. Joseph Hospital in Orange provides a variety of health education for patients and their families while the patient is in acute stages of illness, recovery, and preparing for discharge. The facility is planning to open a metabolic care unit in April, 1976, which will focus on teaching the patient to manage his illness. Programs are offered during the day to in-house patients and some evening programs are offered at minimal fee to the general public. In addition, the hospital foundation has developed and implemented a "Town Hall for Health" series at no cost. The series began five years ago and the Foundation has offered programs including information on Diabetes,

Hypoglycemia, Upper Abdominal Pain, Chronic Lung Disease and Cardiac Pulmonary Resuscitation.

The attendance at the programs has ranged from 500 to 800 participants and is proof that consumer health education is indeed taking place in the acute care sector.

Hoag Memorial Hospital - Presbyterian in Newport Beach, through its Office of Education, has also stressed the importance of patient and community education. They plan to conduct three to four seminars a year which will be free to the public. Seminars in the past year have addressed heart attack, diabetes, and stress. Hoag staff use the team/panel approach augmented by audio-visual presentations when available. The facility also offers an on-going pre-natal and prepared childbirth program which is offered to the public in the evenings. They further plan to implement a closed circuit television system using a pre-taped video recording system for patient education.

These examples are a clear indication that there is a great deal of activity in the acute care sector. Activities of this nature must be documented in order to adequately plan for CHE.

Two years ago, President Ford signed the Health Maintenance Organization Act (HMO) which was aimed at encouraging the development of medical care plans that offer an alternative to the traditional fee-for-service method of paying for medical care. For federal approval, plans must offer a health education program. The HMO Act was seen by many observers as being the foundation for a national health insurance plan because it sets federal standards for scope of services and quality and introduces consumer participation to the board of directors.

Educational Institutions and Schools:

Consumer health education in the community is only one portion of the activities which need to be documented for a clear picture.

Educational Institutions and schools include primary, secondary, and postsecondary institutions, vocational education programs, education-affiliated groups such as the Parent-Teacher Associations (PTA's) and decision-making bodies such as Boards of Education.

The Postsecondary Educational institutions inventory has been developed by the Consortium and includes resources in Orange County, Planning Region A, and Greater Long Beach area, Planning Region B. (Appendix I)

The original inventory of public institutions was a result of efforts by the Coordinating Council for Health Sciences Education (CCHSE). The inventory has been expanded by the Health Manpower Preparation and Health Manpower Development-Continuing Education Committees of the Consortium to include private, non-profit and proprietary schools. The sample of proprietary schools included in the inventory are the participants in the Consortium Health Manpower Education Study - 1975. Included are three universities; eight community colleges; six private, non-profit institutions; and thirteen proprietary schools.

Cooperation between educational institutions and CHE providers is necessary to assist CHE providers with the preparation and selection of educational material related to health care.

CHE activities in the off-campus community in which post-secondary institutions are involved need to be documented, particularly as many of the institutions in the Orange County and Greater Long Beach area are involved in the training of future health care providers.

Health education activities in the secondary school level are important to inventory as students drop out of school prior to graduation and the health education materials they receive may be the only information they acquire.

Moreover, school-related organizations play an active role in linking the school to the community. Such groups as parent-teacher associations (PTA's) need to be contacted to determine in what consumer health education activities they are involved.

Other community groups active in consumer health education for school children are important to include. For instance, in the Irvine Unified School District (IUSD) a Health Awareness Advisory Forum conducted a survey of parents and students to determine whether or not a health education program should be implemented for the intermediate students (grades 6, 7, and 8). The Forum was a cooperative effort of parents, students, teachers, and school nurses and documented health education as an important concern in the community. The survey has led to the development of a four-part curriculum addressing 1) physical health and well-being; 2) emotional growth and development; 3) human relationships; and 4) contemporary health problems. This curriculum has been implemented in grades kindergarten to eighth grade and is presently being developed for high school students. Although designed for students, this kind of education is not health career preparation and can be included in the CHE category - particularly if the family inadvertently benefits from the student's new knowledge.

Cooperation between hospitals and adjacent schools for educational tours with hospital personnel acting as guides and counselors should be initiated as a cooperative effort between community hospitals and local schools to increase student and family awareness of services.

As mentioned previously, this type of information is crucial to youngsters, particularly in light of the California "Certificate of Proficiency" program which was initiated December 20, 1975. This new program allows high school students from age 16 to take a new state proficiency test. Each student who passes receives a "Certificate of Proficiency" which is legally equivalent to a high school diploma.

A major concern is that the new program will increase the number of poorly educated and sometimes functionally illiterate youngsters, most of whom come from low-income and minority families.

Regardless of the positive and negative aspects of the program, it has in effect lowered the compulsory attendance age in California and makes CHE all the more important in intermediate grade levels.

Prevention is a key factor in health care. Teaching children good health habits, proper diet and nutrition, and about contemporary health problems will help to develop an informed and health conscious adult population. Health education for students in the compulsory education system insures a captive, if not totally captivated, audience.

Professional Health Manpower Associations:

Professional Health Manpower Associations include organizations such as the California Nurses' Association and the American Dietetic Association. The inventory of Professional Health Manpower Organizations has been compiled by the Consortium with resources provided by members of the three program committees and the Orange County Health Planning Council, and identifies over twenty-five professional health manpower organizations in the Orange County planning region (Appendix J) and nationally (Appendix K).

Professional health manpower organizations have access to a great deal of resources and information. Many of the associations are actively involved with the community. Yet individuals in the community may be unaware of these resources and the local activities. The kinds of materials and information which are available through these associations at the local, state, and national levels must be documented and more widely disseminated.

Other Potential Sources of CHE:

Community groups, churches, patient/consumer health advocate groups, unions, health planning agencies are also involved in CHE. There should be efforts made to determine the scope of their activities as well.

For instance, the Consortium is currently cooperating with the Orange County Health Planning Council in the development of a Nursing Care Guidebook for consumers. The Guidebook will be designed to inform and educate the reader to the alternatives to nursing care and the determinations leading to the appropriate choices. The Consortium staff developed the nursing home and other home health care check lists from the text which was developed by the Council staff. The check lists are in the process of being revised. Upon completion, the consumer guide would be available to consumers in the area.

Inventories of CHE providers in the Orange County planning region not presently identified should be completed preliminary to planning for consumer health. Moreover, current information must be updated to insure timely and accurate data for planning and coordination. The existing CHE survey will have to be revised and adapted to the various sectors, as it is not a universally applicable format.

The Consumer Health Education Study - 1975 is phase 1 of the attempt to document current activities. It points to potential gaps in CHE activities, but those gaps may be fulfilled by existing efforts in other sectors. To more effectively document programs, the Consortium should assist in the development of standardized information regarding CHE offerings. A standardized format would assist possible participants in making decisions regarding the programs and would assist in the program evaluation process.

Mortality, Morbidity and Utilization Data

The type of mortality and morbidity data available through the CHP "B" agencies for health services planning (Appendix O) needs to be revised and expanded to include information applicable to CHE planning. It is interesting to know that aggregate per capita health expenditures for Orange County in 1974 was \$451.38, 93% of the national average for that year. (Table 4, Appendix O). But for CHE, it is more important to know how people are choosing services and facilities, thus inferring costs through their utilization patterns. That is, are people using emergency rooms for non-emergent ailments which are best treated by general practitioners? If this is the case, what type of CHE is necessary to inform the public and assist them in making the proper choice of a facility. In this example, a decrease in improper utilization of emergency rooms may be followed by corresponding decreases in costs, thereby indirectly affecting the cost structure, which may ultimately benefit the consumer.

Consideration of the health status of the planning area is also important in CHE planning. For instance, the leading cause of death in Orange County (1972) was from diseases of the circulatory system. (Table 1, Appendix O). The CHE provider, armed with this information, may proceed to develop programs educating consumers about cardio-vascular diseases. What is significant about this type of data, however, is that the incidence and risk of heart attack, one category in circulatory system diseases, increases with age and is especially high for males 45 years and older. (Gordon, 1967). With this additional information, it is possible to reach a more selective group of people and more efficiently use the resources. In this regard, it may be desirable to reach a portion of the higher risk individuals through their places of employment. This approach would not only educate the potential patient, but would work toward more understanding on the part of the employer hiring people with histories of heart problems.

Comprehensive CHE Planning and Implementation

A system of planning and evaluating, coordinating, and disseminating CHE activities does not presently exist in this area.

Such a system should include provisions for:

1. Developing, maintaining and disseminating current information of CHE programs for CHE providers and consumers.
2. Coordination of efforts to involve consumers in health planning and CHE activities.
3. Evaluation of all health education materials.
4. Cooperation with communications media in programming CHE materials and for a dissemination vehicle for other CHE activities.
5. Linking local and regional health education organizations for exchange of resources and ideas; to identify gaps and overlaps in CHE programs and research; and to develop methods to increase effective cooperation efforts.
6. Evaluation of existing efforts to make information available to the public and to organizations involved in CHE.

7. Promotion of positive general CHE programs and the reduction of misleading advertising and other health-threatening behavior in communications programs designed for children and general family consumption.
8. Promotion of health education programs and materials encouraging and educating the public to the most appropriate utilization of existing health care services and guidelines to assist them in proper and qualified choices.
9. Establishment of a central location for sources of information and expertise to be used in planning and creating commercial and non-commercial material in CHE.
10. Technical assistance to CHE providers.
11. On-going follow-up and evaluation of CHE offerings and activities through carefully established guidelines. Evaluation should determine program effectiveness and encourage enhanced scope and quality of programs.
12. Identification of gaps and duplications in the system and development of corrective measures.
13. Development of a comprehensive plan coordinating the CHE offerings, activities, audience out-reach and other dissemination, follow-up and evaluation. Plan should address coordination of locations, resources, and program planning, to prevent duplications, encourage exchange and sharing of information and resources, innovation, and efficient and effective use of resources and team approaches to CHE. Accessibility and availability of offerings is an important consideration. Particular attention needs to be given areas of limited resources and populations with multiple disease problems, such as low-income and minority people.

Evaluation of CHE:

Comprehensive guidelines designating criteria for evaluation of CHE must be developed consistent with the documented needs and the concept of preventive health care. Existing efforts must be compared against the guidelines and voluntary implementation of programs and activities compatible with the needs must be encouraged. The Consortium structure will be especially appropriate in developing and maintaining a milieu conducive to cooperation. Innovative approaches, modifications of offerings, coordinated and articulated programs, and a coordinated plan for use of facilities must be encouraged, promoted, and supported.

Full documentation and evaluation of activities must be directed towards the development and implementation of Consumer Health Education Activities Guidelines for proper utilization and allocation of the existing and limited resources available.

Cost of patient care and consequently the relative values of patient education can be discussed in several ways: costs of health care per capita on a given health service area, costs per admission, costs per procedure or service unit, and costs per illness episode. The development of valid and reliable measures of patient education is critical to subsequent program evaluation.

Encouragement of Cooperative Efforts:

Cooperative sharing and exchange of resources will be one method to provide a wide range of CHE programs to a diverse population throughout a certain geographic area. Cooperation will also reduce developmental costs of programs which can be mobilized, video taped, or offered through the television networks. Cooperative efforts can also be effective in meeting the needs of specific consumer health interest groups. These efforts may also serve to bring together those parties affected by a particular disease. For instance, hospital discharge planners, medical social workers, members of the American Cancer Society, and staff in local public health departments cooperate to refer patients to local consumer health advocate groups such as "Reach for Recovery" for patients having had breast cancer surgery.

Patients and family members who have to deal with heart surgery are educated and counselled by a variety of hospital staff and their personal physician. They may also request or be referred through cooperative arrangements to an accredited visitor from the voluntary organization, The Mended Hearts. Volunteers provide assistance and encouragement to the patient and family throughout the process, and provide information as well.

Without the assistance and cooperation of the acute care facilities, this type of valuable public service would not normally be available.

The development of linkages and relationships between segments involved in and/or concerned with CHE will insure cooperation throughout the planning process and is a valuable tool for implementation of plans. This is particularly important because the Consortium is an organization which attempts to achieve optimum utilization of resources allocated for CHE through communication and cooperative efforts of all parties involved to develop and voluntarily implement recommendations. The Consortium does not perform any regulatory functions.

Coordination and Promotion of Innovation and the Team Concept in CHE:

The Consortium must encourage, support, and sponsor local programs for CHE. This includes:

1. Sponsoring or co-sponsoring programs.
2. Promoting and encouraging existing CHE providers to develop new programs and modify existing offerings, addressing needs compatible with Consortium criteria.
3. Promoting teacher preparation programs for the education of health manpower directing CHE.
4. Supporting creative and innovative approaches to CHE.

Serious consideration needs to be given the promotion of the team concept in CHE which can include current trends in team delivery of care. Such activities already exist within the Consortium area, as illustrated by Hoag Memorial and St. Joseph Hospitals.

A system for coordinating the resources compatible with the documented needs must be developed to include all sectors involved in CHE. The Consortium provides the vehicle to bring educators and consumers together to plan for CHE. Efforts should be made to encourage and/or provide programs which will meet the needs of consumers with the most efficient utilization of resources.

Barriers to CHE Utilization:

CHE program utilization and effectiveness will be determined in part by the availability and accessibility of resources.. Especially important for the poor, elderly, and infirmed, is the geographic distribution of resources and costs of offerings.

With the escalation of medical costs, few people are able to meet medical care financial obligations, particularly on a fee-for-service basis, resulting in a large growth in voluntary health insurance since World War II. Financial resources remain, however, a common determinant of accessibility to health services. This is especially true for certain segments of middle-income consumers who do not qualify for Medi-Cal but do not have the opportunities or resources to participate in a health insurance program, or who do not have adequate coverage. They are often unable to handle medical emergencies or long-term illnesses.

The health insurance industry should encourage providers (acute and skilled facilities and private practitioners) to establish and operate programs in patient-education supported financially through existing payment mechanisms and covered in health insurance policies.

The CHE survey conducted by the Consortium attempted to document what, if any, consumer education services were specifically reimbursed by existing health insurance carriers. Responses indicated no health education services offered in the public and voluntary health agency sectors presently covered by health insurance plans.

Proper and timely CHE may contribute to reduced costs by decreasing wasteful and unnecessary utilization of health services. Education would conceivably expose potential patients to the most appropriate use of local services. Indirectly, the effectiveness of medical treatment may be increased. For instance, pre-operative instruction for in-patients to undergo surgery has resulted in significant increases in early discharges among patients receiving intensive instruction as opposed to those not receiving such information.

Patient education has also been determined to lead to improved quality of care with respect to health care outcome and patient follow-through of treatment. The patient education program for diabetic patients at St. Joseph Hospital has seen success in a reduction in patient return for successive incidents of diabetic coma.

Data on the health status of county residents is available but does not appear to include information on consumer utilization patterns, including the source of their information on various health care providers. (Appendix O). In order to effectively plan CHE services for the Orange County population, it is recommended that a survey be conducted to document information on utilization and informational sources.

Because of the unusually high educational attainment levels in the County, it may be that the most effective way to reach the citizenry is through the written media as opposed to audio-visual methods, although it is suspected that the reverse may be correct. Literature tends to indicate that many consumers get their information on providers by "word of mouth" through family members, friends, and neighbors. If this is the case, any system of information dissemination must take this into account.

Regardless, many individuals are denied access to health care services because they do not have the necessary information to locate services. They do not know how to enter the system. Information on the nature and range of available health services is difficult to obtain. There are agencies or institutions in Orange County providing health information. Through the Tel-Med program, a free telephone health library for the public, consumers in Orange County can receive health information via telephone tapes. A public service of the Orange County Medical Association, the Tel-Med library includes tapes addressing birth control, cancer, care of the patient in the home, first aid, drugs and alcohol, heart, and dental information.

In addition, Community Referral and Information Service in Orange County provides consumers with information about and referral to health resources in their community.

The nature of the information and the manner in which it is presented is also important to consumers. There have been efforts both statewide and nationally to simplify forms, contracts, and agreements, making them comprehensible to the average consumer.

The National Association of Insurance Commissioners is the national body regulating the insurance industry. Approximately three years ago, the Association initiated a program to reduce the complexity of insurance policies, revising the language to an eighth grade equivalency.

The commissioners unfortunately found legal ramifications made that thrust more difficult than originally anticipated. The program has met with modest success in revision, but there are phrases mandated by legislation or court interpretations which had to be included verbatim. Therefore, although reduced in complexity, it is not to the degree originally planned. There are concerted efforts to date to continue this simplification process.

It should be noted that a majority of Americans are covered by group insurance, usually through their employers. In these cases, the master policy is issued to the group through the employer and each individual participant is issued a booklet explaining coverage in layman's language.

Efforts to develop nationally uniform insurance policies, on the other hand, has met with small success due to the complexity and varying legislative requirements in each of the fifty states, the District of Columbia, and Puerto Rico. The Health Insurance Association of America includes the major health insurance writer agencies in America. There are efforts on the part of the Health Insurance Association and various providers, including the American Hospital Association, American Medical Association, and the American Dental Association to standardize claim forms which would ultimately result in a reduction of complexity and confusion for the providers and the consumers.

These efforts have resulted in national individual and group claim forms approved for use by the insurance industry and the American Medical Association. There is also a national claim form for dental coverage as approved by the insurance industry and the American Dental Association. In California, there is a claim form in use which closely resembles the nationally approved form for hospitals. (Form AP4)

These voluntary efforts to revise and simplify health insurance policies and claim forms are necessary actions to encourage consumer understanding and interest in his own health care and to insure greater accessibility to that care.

The organization of the health care delivery system can also exert an important influence on accessibility for the consumer. Extensive red tape to enter the system and the limited hours during which services are available represent the kinds of deterrents which conceivably discourage consumers from seeking appropriate care.

There needs to be concerted efforts in all areas, providing direct or indirect health care to reduce the amount and complexity of paperwork to which the consumer is exposed.

Uniform billing systems, insurance policies, and claim forms are the beginning of the task which must be conducted at all levels of the health care industry.

Uniform information and forms would also make translating to other languages more administratively and economically viable. Forms would only need to be translated once into any one language and a master translated copy could be made available to any facility upon request. This type of arrangement would make it possible to translate into any number of languages, thus increasing the capacity and effectiveness of facilities serving non-English speaking populations.

Patient admissions and consent forms should also be reviewed for content and length to determine possible areas of revision. This action could shorten the admission process as well as reduce the confusion for the patient.

CHE materials reviewed by the Consortium appear, on the whole, to be sensitive to the lay person's knowledge of health care and diseases. The literature received when conducting the survey for the Consumer Health Education Study from the voluntary health associations were especially good examples of literature which is comprehensible to the average person. In addition, there is already available a substantial amount of literature and services for Spanish speaking peoples. (Table 1)

The on-going documentation of consumer guides to health care is included in a bibliography and is made available upon request. (Addendum S). This bibliography can assist the consumer or CHE provider in obtaining materials pertinent to finding a physician or dentist, or to other health-related problems.

Table 1
CONSUMER HEALTH EDUCATION MATERIALS
BY VOLUNTARY HEALTH AGENCY AND TYPE OF MEDIA USED
(Orange County, California)

VOLUNTARY HEALTH AGENCIES SAMPLE	TYPES OF MEDIA USED AND LANGUAGES AVAILABLE															
	Publications Newsletters	Individual Mailings	Mass Mailings	Mass Media	Individual presentations	Group presentation	Telephone contacts	Recorded Messages	Answering services	Hot line	Lecture and seminars	Instructors	Multi session classroom	Speaker's Bureau	Audio-visual Materials	Other
American Cancer Society Orange County Unit	E S	E S	E	E	E	E	E				E	E	E	E	E	
American Heart Association Orange County Chapter	E LS	E	E	E	E S	E LS	E S				E LS	E	E	E LS	E LS	E
American Red Cross Orange County Chapter	E S	E	E	E	E S	E S	E S				E S	E S	E S	E S	E S	
Arthritis Foundation Orange County Branch	E S	E S	E	E S	E	E	E S				E			E	E	
Lung Association of Orange County	E (S)	E	E	E (S)	E	E	E				E	E	E		E (S)	
National Foundation March of Dimes Orange County	E S C	E	E	E S	E	E	E	E	E	E	E	E S	E	E	E S	E
Orange County Department of Mental Health	E S			E	E S	E S				E	E	E S	E S	E S	E S	
Orange County Health Department	E S	E S	E S	E S	E S	E S	E S				E S			E S	E S	

LANGUAGES AVAILABLE

E English
S Spanish
C Chinese
J Japanese
T Tagalog
G Greek
I Italian
N Navahoe
O Other:
L indicates Limited
(S) Some Spanish

"Informed Consent" should be included in CHE concerns as it is an essential patient education function in which understanding becomes the essence of consent and therefore becomes necessary to the treatment process. The development of a glossary or lay encyclopedia explaining and graphically demonstrating the various procedures performed in hospitals and laboratories should be encouraged. The text should be written in lay vernacular and should include information on routine procedures and surgeries, for instance.

The systems for information dissemination must also consider preferences prevailing in various ethnic or poverty communities which result in under-utilization and/or failure to use services in the most appropriate manner. Individuals in lower socio-economic categories tend to use emergency rooms and public clinics most frequently. Certain cultural groups have tended to rely on ethnic folk providers and herbal pharmacists, using licensed health providers and facilities only when conditions have reached acute stages. Proper and timely utilization may have resulted in a faster recovery rate for the patient and decreased costs to both the patient and the health care delivery system. Medical care is not available to limited segments of our communities because these cultural barriers exist which can be broached only by education that demonstrates an understanding of the reasons for these barriers. Superstition and fears, misconceptions and the use of ineffective home remedies can be overcome by appropriate education. Efforts need to be made to reach these consumer groups with special needs.

Coordination and Dissemination of CHE:

There does not appear to be any efforts to coordinate and disseminate CHE information in Orange County other than within a particular voluntary health agency or acute care facility, etc. These attempts do not include comprehensive inter-agency coordination and thus, offerings and dissemination are fragmented.

As previously mentioned, the consumer must obtain CHE information from a variety of autonomous sources. A system for dissemination of information to the consumer is essential. Careful consideration should be taken to include non-traditional methods of outreach. Input and participation should be solicited from agents in the media, including educational television. Programs should be directed to both specific and broad groups of individuals in all age groups. The system should motivate consumers and encourage them to become actively involved in their own health care.

The linkages and cooperative relationships of all efforts in CHE must be maintained and expanded. A dissemination system needs to be developed based upon an accurate assessment of current activities. A prime concern should be the involvement of consumers and new methods of motivation and encouragement for consumer involvement in their own health care and prevention of disease.

Efforts should be made to use available methods in new and innovative ways. There should be promotion of positive general CHE programs and reduction of misleading advertising and other health-threatening behavior in communications programs designed for children and general family consumption. The communications vehicle should encourage and educate the public to the most appropriate utilization of existing resources and assist them in proper and qualified choices.

The Consumer in the Health Planning Process

Consumer participation in the health planning process is closely linked to increasing appropriate utilization of health care facilities, reduction in barriers to access, increased quality of care, and an informed public involved and interested in their personal health regimen. Consumers were specifically given a role in the new legislation as one means to increase accessibility, acceptability, continuity, and quality of health services provided in their areas. (PL 93-641). Consumers on the various health planning bodies are to be representative of the social, economic, racial, and linguistic populations as well as the specific geographic areas for health services and major individual purchasing of health care.

The historical problem with consumer participation has been the lack of citizen involvement. In some instances, consumers have been merely "window dressing," having little input into the decision-making process and almost no impact on final recommendations or actions. This has often resulted in alienation on the part of the consumer representative and a loss in community legitimacy for the agency or board. Sometimes, the consumers become a rubber stamp, accepting staff planning and decisions without testing them out in terms of the community needs. This is a special problem in health because health planning requires professional staff and technical expertise.

Every effort should be made to identify consumer members of boards based upon true representation and concern with issues related to and affecting consumers. Their concerns should not only be those of their particular special interest groups but the concerns of all consumers.

Typically, there is no vehicle developed for leadership training, and education in health services terminology and techniques of planning in health planning bodies. Means for development in these areas is integral to the planning process and necessary to enlarge the potential base of consumer participation and to help the Board gain the needed specialized knowledge.

Increasing the knowledge of consumer and other representatives will result in decreasing frustrations and feelings of impotence. Also increased will be board effectiveness, for decisions may be based upon empirical data and knowledge rather than subjective feelings which may have no particular bearing on the decision.

Realizing the efficacy of informed Board and committee members, the Orange County Health Planning Council conducted a five week course in Community Health Planning available to the general public in 1975.

The program was well-attended by Council board and committee members, both providers and consumers. Addressed were issues relevant to health planning in general. The course was innovative in these respects. It provided students with credit and a certificate of completion from one of the local community colleges. This gave consumers and provider representatives in the health planning milieu a shared learning experience and certificate.

Efforts need to be made to identify potential consumer members who are representative of community concerns. Once identified, a program educating

board members, in general, needs to be developed and executed. One cannot assume that just because an individual represents a "provider" interest on the board, that he is familiar with health terminology; PSRO and utilization review procedures; specific data relative to the health planning area; existing planning and evaluation techniques; and other such items and issues integral to the planning process.

Steps to insure consumer participation as developed in the CHE Plan draft by the South Central Los Angeles Health Consortium has been adapted by the Orange County - Long Beach Health Consortium for use in Orange County. (Table 2).

Alternative solutions to the problems of consumer health education and consumer participation included in the following section are being addressed by the Plan Committee of the Consortium and prioritized recommendations for effective planning are being developed.

Steps Which Can Help Assure True Consumer Participation

In Planning and Delivery of Health Care

I. Assure truly representative consumer participation on the HSA governing bodies.

- A. Provide detailed by-laws and plans to assure that the consumers on the governing boards do indeed represent the social, economic, linguistic, and racial segments of the population as well as the geographic areas of the Health Services Area.

This can be facilitated by:

1. Bringing in acknowledged leaders of the community - i.e. church leaders, community center leaders, leaders of informed community groups.
2. Soliciting written recommendations for governing body representatives from appropriate community-based organizations including: community development organizations, community action agencies, and other private and public non-profit agencies and organizations whose membership or staff work primarily on behalf of the significant sectors of the general populations.

II. Provide extensive and relevant training programs for consumer and provider representatives on HSA governing bodies.

- A. Topics addressed should include but not be limited to:

1. Parliamentary procedures
2. Health care background
3. Community development
4. Needs assessment models and evaluation of data collection
5. Alternatives to existing health care delivery
6. Better communications
7. Community awareness -- including awareness of values and assumptions of various sub-cultures; better understanding of various age groups, economic differences, and sexism
8. Alternatives to existing health care delivery systems

III. Each HSA would develop a thorough and on-going citizen participation structure to inform all people (consumers and providers) in the health service area about health care, and solicit suggestions about health needs and criticism of the Annual Implementation Plan and Health Systems Plan.

IV. Conduct meetings of the HSA governing body and Sub-area Advisory Councils in community-based facilities outside of the hospitals.

Meetings could be rotated throughout community centers, public schools, churches, hospitals, health agencies, health professional associations, and other community centers to insure equal access to meeting places and to encourage wide public attendance. Efforts should also be made to rotate meetings geographically to insure equal access to people in different areas of the health service area. This is especially important in Orange County because of the large geographic size of the HSA.

V. Public hearings should be carried out throughout all areas and not be limited to one per area.

VI. Assure thorough data collection which deals directly with the needs of the people of the Health Service Area.

- A. Compile other data in addition to "bed counts" which are relevant to community needs.
- B. Use community members and those knowledgeable and sensitive to relevant sub-cultures to carry out data collection. (For example, many Mexican-Americans would find it easier to express their health needs to someone who understands the subtleties of their culture and who is bilingual.

VII. Develop Sub-area Advisory Councils in all areas of the HSA's in order to assure more representation across various segments of the Health Service Areas. (Insure sub-areas include minority and poverty representation).

VIII. Have a professional consumer on the Statewide Health Coordinating Council.

This person would be fully paid, extremely knowledgeable about the needs of consumers and health care and would represent all consumers. All board members should receive equal reimbursement.

IX. The consumers on the SHCC should represent the population of the State.

Not only should they be leaders respected by the communities, they should also reflect the ethnic balance of the state.

X. Utilize consumer input in developing quality-of-care criteria for monitoring HSA planning and health care delivery systems.

- XI. Utilize significant consumer groups in all levels of planning and implementation of health care -- beginning with adequate representation on the National Health Council.

Adapted from "Steps...Health Care" included in the Consumer Health Education Plan - Draft by the South Central Los Angeles Health Consortium, 1975.

ALTERNATIVES

A select number of alternatives have been developed by the Consortium addressing the problems in consumer health education and consumer participation.

The first alternative would be to leave matters in their current state. If documentation, planning, and coordination of existing and planned programs and existing efforts to include consumer participation is not implemented, health facilities and providers would continue to be inappropriately and wastefully utilized. Moreover, consumers would continue to remain unaware of resources and alternatives available to them for disease treatment, control, and prevention. The consumer and the entire health delivery system would ultimately suffer if treatment instructions are not carried out; emergency rooms will continue to be impacted by inappropriate utilization; there may be more frequent and serious outbreaks of communicable diseases; and wasteful duplication of existing CHE programs will continue. Furthermore, isolated, token efforts to assure consumer participation may proliferate, totally alienating citizenry who may be valuable additions to the health planning process.

An alternative solution that would only partially coordinate CHE activities would prove ineffectual and costly. To identify CHE activities in one segment (i.e. voluntary health and public) omits the activities, contributions, and resources existing in other segments and does not properly address the multitude of CHE in the region.

The most reasonable and viable alternative is to develop a regional plan for CHE which is linked to state and federal planning efforts and which is integrated into a regional health manpower planning system. This system would coordinate and plan CHE activities and efforts to assure true consumer participation and should address the issues explored in this plan. The system should be coordinated by a centralized decision-making body which governs a specific agency responsible for implementing planning, decisions and programs within a specified geographic area. The central body should be comprised of representatives from all sectors involved in or concerned with CHE.

Data and activities integral to this system must be identified and implemented, including:

1. Inventories of consumer health education providers in the Orange County planning region not presently identified must be completed preliminary to planning and maintained current. Current information must be updated to insure timely and accurate data for planning and coordination. Full documentation and evaluation of activities must be directed towards the development and implementation of Consumer Health Education Activities Guidelines for proper utilization and allocation of the existing and limited resources available. Every effort should be made to develop a consumer health education delivery system which is compatible with the intent of PL 93-641, the National Health Planning and Resources Development Act of 1974.

2. The linkages and cooperative relationships of all efforts in consumer health education must be maintained and expanded.
3. A dissemination of information systems needs to be developed based upon an accurate assessment of current activities. The Consortium should promote a communication vehicle to bring information regarding programs to potential participants. Efforts should be made to use available methods in new and innovative ways. There should be promotion of positive general consumer health education programs and reduction of misleading advertising and other health-threatening behavior in communications programs designed for children and general family consumption. The communications vehicle should encourage and educate the public to the most appropriate utilization of existing resources and assist them in proper and qualified choices.
4. Of prime concern in the system should be the involvement of consumers and new methods of motivation and encouragement for consumer involvement in their own health care and prevention of disease.
5. More complete and appropriate mortality and morbidity statistics delineating the needs for specific programs must be developed.
6. The system for coordinating the resources compatible with the documented needs must include all sectors involved in consumer health education. The Consortium provides the vehicle to bring educators and consumers together to plan for consumer health education. Efforts should be made to encourage and/or provide programs which will meet the needs of consumers with the most efficient utilization of resources.
7. The Consortium should assist in the development of standardized information regarding consumer health education offerings. A standardized format would assist possible participants in making decisions regarding the programs and would assist in the program evaluation process.
8. There should be a coordinated effort statewide to document, evaluate, plan, and implement consumer health education activities. Activities and offerings should be directed to locally-defined needs, but should utilize a common format and integrated information dissemination system. The statewide effort should provide for cooperation and sharing of information with the possibility of mobile offerings which could be shared regionally and/or statewide, depending upon the needs.
9. Although consumer health education if offered at local or regional levels geared to locally-perceived needs, there must be coordinated efforts Statewide and possibly nationally:
 1. To insure consistency and quality of offerings.
 2. To share information, data, and resources.
 3. To maintain a system which includes the latest information attainable.
 4. To more effectively assess the impact of trends in mortality and morbidity.
 5. To address the gaps and duplications in offerings through funding.

Statewide efforts to coordinate and plan for consumer health education is essential, but must be conducted in concert with and include local input. The Statewide activities should enhance the local planning process and serve to strengthen the local efforts, making them more effective.

State departments of education and local school boards should assume greater responsibility for the development of health curriculums. In so doing, the schools should look to health departments and voluntary health agencies for assistance in providing continuity and resources.

Health departments and voluntary health agencies should make available resources for health education programs in business and industry. These resources should be utilized to supplement in-plant health information and counseling efforts.

More applied research in educational techniques and methods should be undertaken to supplement and draw from physical and social science research findings, particularly those which apply to health attitudes, motivation, and behavior.

Health education personnel should be given courses covering the needs of the rapidly expanding health field, including administration, community organization, and action-planning.

Schools of public health should maintain a department or unit that specializes in relevant areas of education and communication. Schools of public health and schools of education should cooperate in training health educators.

Although CHE is generally offered at the local or regional levels, there need to be coordinated efforts Statewide and possibly nationally to develop quantifiable and consistent evaluative measures of the quality of CHE; to clarify CHE reimbursement procedures for providers; to more effectively assess the impact of trends external to the health education system; and to address the gaps and duplications in programs through funding.

Statewide efforts to coordinate and plan CHE is essential but must be conducted in concert with and include local impact. The Statewide activities should enhance the local planning process and serve to strengthen local efforts, making them more effective.

Development of linkages and cooperative relationships between the Consortium and sectors involved in or concerned with CHE is essential to the planning process. This is particularly important because the Consortium is an organization which attempts to achieve optimal utilization of resources allocated for health manpower continuing education through communication and cooperative efforts of all parties involved to develop and voluntarily implement recommendations. The Consortium does not perform any regulatory functions.

Early in the development of the Consortium, the Board of Directors was expanded to increase participation to all groups identified with health manpower and consumer health education. As a result of this expansion, the number of consumers and consumer health education providers represented in the Consortium and on the Board has increased, allowing for greater opportunities for cooperative efforts.

The Consumer Health Education Committee has acted as a vehicle to join local health education organizations, health educators, and consumers in a cooperative relationship designed to share ideas, identify gaps and overlaps and proffer alternative innovative approaches in CHE.

In addition, the Consortium is presently developing other linkages and cooperative efforts which will lead to the coordination of CHE programs in order to avoid duplications of programs, promote creative implementation of needed programs, promote quality in programs, and attempt to effectively integrate the use of information, resources, and community participation. These efforts should be encouraged and maintained as the Health Systems Agencies are designated and become operational. Particular consideration should be given to the Orange County - Long Beach Health Consortium as the recognized health manpower planning body in the region, and furthermore, the only body involved in regional comprehensive documentation of CHE activities in the Consortium area.

Although the interpretation of PL 93-641 indicated the Health Systems Agency cannot contract for an entire single function as designated in the law, there do not appear to be any guidelines or regulations precluding the HSA from contracting for portions of any specific function. The HSA's should contract with the Orange County - Long Beach Health Consortium to provide the CHE planning component of the Health Systems Plans and the Annual Implementation Plans. Any additional funds available for CHE planning should consider the Consortium as a likely candidate.

The Consortium can identify CHE activities that have existed, been proven effective, and can be offered on a regularly scheduled basis through the evaluation mechanism being developed. Consideration can be given to programs offered in different geographic locations, in the creative ways of utilizing audio-visual resources, making CHE more accessible and conserving development costs.

As previously indicated, there is no comprehensive system of planning, evaluation, and coordination of CHE in the Consortium area. Through the Orange County - Long Beach Health Consortium, however, actions have been initiated to develop such a system. Without the necessary data and objective criteria on CHE to document the real needs, the system will be rendered ineffective, basing its decisions upon subjective criteria and "felt" needs.

There are numerous alternatives to the CHE dilemma in this area. Cooperation and voluntary implementation of responsible planning, coordination, and implementation of recommendations is the key.

RECOMMENDATIONS

The Orange County - Long Beach Health Consortium should be maintained as the CHE planning body in the region, taking responsibility for the health manpower portion of the HSA's health planning charge. CHE activities and functions of the Consortium can be carried on as a part of the planning continuum and with appropriate funding, recommendations developed in this plan can be implemented by the body which originated them. In the CHE system, the Orange County - Long Beach Health Consortium would be the local organization responsible for regional planning, coordination, and data collection.

Data collection should be coordinated on a state-wide basis, and if possible, made compatible nationally. The state and federal levels must also address Medi-Cal and Medicare reimbursement for CHE (patient education).

National efforts would address consistency of program offerings, their evaluation in terms of quality, and appropriate levels of funding to develop and/or continue activities.

ORANGE COUNTY - LONG BEACH HEALTH CONSORTIUM, INC.

Consumer Health Education Plan
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LEGISLATION

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| PL 79-725 | Hospital Survey and Construction (Hill-Burton) Act of 1946. |
| PL 89-239 | Regional Medical Program, 1965. |
| PL 89-749 | Comprehensive Health Planning Act of 1966. |
| PL 93-641 | National Health Planning and Resources Development Act of 1974. |